BRITISH COLUMBIA

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DECISION NO. 2014-HA-002(b)

In the matter of an appeal under section 46 of the *Hospital Act,* RSBC 1996, c.200

BETWEEN:	Dr. Stephen Todd Sorokan	**APPELLANT**
AND:	Fraser Health Authority	**RESPONDENT**

BEFORE: A Panel of the Hospital Appeal Board
David G. Perry, Chair
Corey Van't Haaff, Member
Dr. Kevin Doyle, Member

DATE: July 11, 12, 13, 14 and 18, 2016

PLACE: Vancouver, British Columbia

APPEARING:

For the Appellant:	Trevor R. Thomas, Counsel
For the Respondent:	Penny A. Washington, Counsel Melissa Perry, Counsel Kayla Strong, Articled Student

APPEAL

[1] This is an appeal by Dr. Stephen Todd Sorokan ("the Appellant") of a decision of the Board of Directors of the Fraser Health Authority ("FHA" or "the Respondent") rejecting his request to be returned to the on-call rotation schedule at the Royal Columbian Hospital ("RCH") Department of Pediatrics Neonatal Intensive Care Unit (the "NICU"). The decision under appeal was made at an in-camera meeting on May 9, 2014 and communicated to the Appellant by letter dated May 21, 2014. That decision affirmed the October 12, 2013 Search and Selection Committee meeting decision not to recommend appointment of the Appellant to a full time position at RCH. On-call privileges flow from this decision which in effect also refused the Appellant's alternative request for an allotment of two on-call shifts per month in that same department. In his notice of appeal, Dr. Sorokan stated that "[d]espite the submissions made by Dr. Sorokan during the January 29, 2014 meeting, the Board of Directors choose to only address RCH's selection process for hiring its new paediatrician and failed to comment on the decision to unilaterally reduce Dr. Sorokan's shifts to two per month and then to completely exclude Dr. Sorokan from the call schedule in December 2012….The Board's decision confirms that Dr. Sorokan will not be returned to the on-call rotation at RCH." The notice of appeal further states that the "appeal concerns

the unauthorized and unlawful altering of Dr. Sorokan's privileges as a member of the Department of Paediatrics at [RCH]."

[2] On March 30, 2017, following the close of the hearing and before these reasons were issued, the Appellant applied to reopen the hearing to introduce new evidence and to amend the remedy sought.

[3] For the reasons set out below both the Appeal and the application to reopen are dismissed.

BACKGROUND

[4] The Parties helpfully submitted an agreed statement of facts. For the benefit of the reader, it has been appended to this decision as Appendix A. We will make specific reference to only some of these facts but we adopt them in whole as true.

[5] The appeal arises because the Appellant had two on-call shifts per month removed effective January 2013 by the RCH NICU department which decision was upheld by the FHA Board of Directors May 9, 2014.

[6] The Appellant is a neonatologist. Beginning in 2002, he practiced at RCH as a Neonatologist and Pediatrician.

[7] The RCH NICU consisted of five members. RCH has a unique organization as testified to by the Appellant, Dr. C and Dr. K (members of the department at all material times) and Dr. S, the Regional Department Head for the NICU.

[8] RCH Department of Pediatrics members practiced as both neonatologists and pediatricians. Neonatology is the care of new-born infants, more specifically infants at risk because of premature delivery, underweight or suffering medical complications. It is a wholly hospital-based practice. Pediatrics is the care of children up until around age 18 and can be conducted either in the hospital or in private clinics.

[9] Most other neonatology and pediatric departments operate in cooperation but separately. Neonatologists attend at high-risk births and are on call for complex patients. However, the post-natal care is generally carried out by either pediatricians or general practitioners under the general supervision (as needed) of a neonatologist. As a result, in most departments a neonatologist would not, for example, conduct pediatric rounds.

[10] RCH elected around 2004 to combine their neonatology and pediatric departments. On-call shifts for the entire year (24/7/52 – in other words around the clock care throughout the year) were divided between the 5 members of the department. Hospital based direct patient care services are paid for by the Medical Services Plan (MSP) on a fee for service basis. At RCH, MSP fees were paid to whichever neonatologist/pediatrician was on call and the shifts shared equably. This was the major source of income for all members of the department. This meant typically six 24-hour shifts per month or 72 shifts a year. A shift was 24 hours and during night shifts the person on call slept at the hospital when not needed for patient care. All the shifts were for 24 hours. It

was common to split them into evening and day shifts to accommodate personnel schedules.

[11] RCH had 12 Level 3 (also called tertiary) beds and 12 Level 2 (also called secondary) beds. The levels depend on the acuity of the patient. These babies are as young as 25 weeks and can weigh under 380 g at birth according to Dr. K. Because of their vulnerability success rate with these babies considers both mortality (how many survive) and morbidity (how many complications such as brain or organ damage and future development difficulties) the patients experience. Level 2 beds are for babies born after 32 weeks' gestation.

[12] RCH became a nation-leader in Neonatology and Pediatrics according to rankings kept by the Canadian Neonatal Network, a national organization that charts results for neonatal departments across the country. Nonetheless, the most acute cases have a 30-40% survival rate and when born with 23 weeks gestation only 10-15% survive without challenges.

[13] The Appellant was a key member of the RCH NICU department and contributed to its success. All members of the department had great pride in their model which required a high-level of cooperation including pooling of income and equable sharing of unpaid responsibilities.

[14] In addition to on-call, the neonatologists/pediatricians have other responsibilities. They conduct rounds most days. Although the team approach meant all patients were under the care of the on-call specialist, the admitting neonatologist/pediatrician would have primary contact with families and would continue treatment during rounds. Family conferences were necessarily time-consuming as there are many end of care and end of life decisions, all obviously heartbreaking for the families, involved with such vulnerable babies.

[15] There were also administrative duties, department meetings, quality control meetings and teaching responsibilities as the University of British Columbia medical students trained at RCH. Most members of the RCH Department of Pediatrics also maintained a private practice in pediatrics.

[16] The Appellant testified one on-call shift paid approximately $7000 meaning each member of the department was paid approximately $504K per year (6 shifts x $7000 x 12 months). Most neonatologist/pediatricians also earned income from private practice and fees for teaching and from a Medical On-Call Availability Contract ("MOCAP") with the FHA. The Appellant testified he grossed around $100,000 from his private practice. No evidence was lead as to his net income. Evidence as to teaching or MOCAP income was scarce.

[17] Around January 2009, FHA determined that Level 3 services in the Fraser Health region should be consolidated at Surrey Memorial Hospital ("SMH"). The plan was for all Level 3 beds to be transferred from RCH to SMH while RCH retain 12 Level 2 beds. The significance is that neonatologists are trained to treat acute patients which require tertiary care. Less acute patients in Level 2 can be treated by pediatricians or even family doctors if under the general supervision of a neonatologist. That is the model of departments other than RCH. In that model the Neonatologist manages care but is not the "hands-on" provider of care after the acute phase.

[18] The FHA announcement was, to say the least, highly controversial. The RCH NICU department bitterly opposed the transfer. Drs. C and K are members of the RCH department and have been for many years. They testified that the unique model of combined Neonatologist/Pediatric care at RCH would end if the Level 3 beds were transferred to SMH. They also came to have grave concerns about the safety of the vulnerable patients in their care as in their view the proposed transfer did not meet the high quality of care offered at RCH.

[19] As a result, the RCH department vigorously lobbied against the proposed transfer and ultimately decided individually to not apply for privileges at SMH even if that meant no access to Level 3 beds at RCH.

[20] The Appellant took a different approach. He quite candidly testified that his primary objective was to continue to work in a tertiary ward. Although he testified that he liked his coworkers and felt part of the team at RCH, the ultimate location (RCH or SMH) did not influence his decision to remain committed to providing tertiary care. In addition, he did not share the concerns of his fellow department members that the particular RCH model of care was so important that the FHA proposal should be opposed in order to protect the safety of patients, nor was he concerned that the relative quality of care at the new SMH department would compromise patients in any way. As a result of his decision to follow the Level 3 beds, the Appellant participated actively in the transfer, was an active member of the transition committee, engaged in communication with senior administration at FHA and sought, and was granted, privileges at SMH. He also cooperated closely with Dr. V, the department leader at SMH in planning the proposed transfer.

[21] The Appellant was aware that his reaction to the transfer was diametrically opposite that of the remaining members of the RCH department. He explained the difference as arising from his personal background of being involved with the British Columbia Medical Association (now Doctors of BC). In his view, it was the role of the executive to make decisions and the membership should abide by them. If FHA had determined that Level 3 beds should be consolidated at SMH he was perfectly willing to go along with that decision and assist in any way possible.

[22] The Appellant's cooperation with the transfer was badly received by the other members of the RCH department. Dr. C in particular had a long friendship with the Appellant, had assisted in obtaining a position for him at RCH and had worked closely with him for many years developing the first-class department at RCH. The Appellant's role in facilitating the transfer was perceived as a betrayal of the RCH program and his announcement that he intended to transfer the bulk of his hospital practice to SMH was seen as contributing to the potential demise of tertiary care at RCH.

[23] The Appellant was known amongst his colleagues to be assisting in the proposed transfer. A "Project Charter" was distributed February 5, 2009, which outlined a comprehensive plan for the transfer of 12 Level 3 beds from RCH to SMH. The Appellant from RCH and Dr. V from SMH were named as part of the Steering Committee for the transfer.

[24] This angered many of the neonatologist/pediatricians in the RCH department. Dr. C emailed his department members and Dr. V February 17,

2009, raising issues about potential effects on quality of care at RCH during the transfer period as nurses began to resign in order to follow the tertiary beds to SMH. He also raised concerns about loss of income for the RCH department members as they relied on MSP premiums for the bulk of their revenue. He concluded by saying "I hate to reemphasize it again, but I have no doubt that you, Todd [the Appellant] and [Dr. V] will be consider (sic) co-responsible for these both issues, of decreasing RCH ability to provide care for the babies and also for our lost income and so on, as your presence on the transition team comes also with accountability (sic)."

[25] The positions of the RCH physicians and the Appellant became entrenched throughout 2009. In a March 5, 2009 department meeting the minutes note "The Impact Analysis, we feel, for this move will be increased mortality and morbidity in the babies and a devastating experience for the families." On April 2, 2009, Dr. V and the Appellant presented scenarios for the transfer which resulted in a "long heated discussion which lasted for an hour". Dr. C and Dr. K said they would not move to SMH because of their "concern over safety of the tiny babies". On May 7, 2009, the department (except the Appellant) resolved that "each member could decide whether they either want to work full time in Surrey or at the Royal Columbian and that they should make a decision as to which site they want to work at and stay with it."

Positions of the parties on appeal

The Respondent

[26] The Respondent submits that the central issue in this appeal is whether the Appellant's Active Staff Privileges include the "right" to be included in the on-call schedule at his secondary site, RCH, regardless of any need for his services at that site.

[27] It is the Respondent's submission that while the Appellant has an obligation to participate on an equitable basis in the on-call schedule at his primary site, SMH, he has no such obligation or entitlement at his secondary site, RCH.

[28] Further, the Respondent submits that the Appellant's inclusion on the on-call schedule at his secondary site (RCH) is an operational matter managed by the RCH group and that as such, it is not "a decision of a board of management that modifies, refuses, suspends, revokes or fails to renew a practitioner's permit to practice in a hospital" and as such is not a decision that is subject to appeal to the Hospital Appeal Board (the "HAB") under section 46 of the *Hospital Act*.

The Appellant

[29] The Appellant submits that the RCH Department of Pediatrics' decision to reduce, and then exclude him, from the RCH call rotation has had a significant financial and emotional impact on him. The on-call and professional responsibilities associated with his practice at SMH are considerably less than full-time practice as a member of pediatrics at RCH. In addition to the financial aspects of the FHA decision, the Appellant submits that he experienced an

emotional loss due to the loss of strong professional ties to the hospital, staff and the community developed over his 10 years of practice at RCH.

[30] The Notice of Appeal filed by the Appellant August 18, 2014, sought reinstatement to the on-call rotation at RCH and financial compensation for loss of shifts. At a pre-hearing case management conference held July 20, 2015 the Appellant agreed to clarify the remedy he was seeking on appeal. By letter to the HAB dated August 14, 2015, the Appellant sought two on-calls shifts at RCH per month, morning coverage of the pediatric ward at RCH and costs. This was the relief sought at the opening of the oral hearing.

[31] In the course of cross examination of the Appellant, after the close of the Respondent's case[1], the Appellant indicated he wanted to abandon that remedy.

[32] The Appellant was granted a lengthy adjournment with the evidentiary rule against conferring with counsel during cross examination waived with the consent of counsel for the Respondent.

[33] The Appellant then sought what the Respondent has correctly characterized as a "declaration" with "policy" recommendations remedy. The policy referred to differed slightly in the Appellants' oral and written closing. The final remedy sought was:

1. A declaration that the FHA decision under appeal modified, revoked or constructively revoked the Appellant's privileges at RCH (termed hereafter the "Declaration");and
2. That the Panel recommend that the FHA do the following:
    i. review the Medical Staff Bylaws and Medical Staff Rules with a view to ensuring that processes exist (and are adhered to) for resolving disputes related to physicians' call and the assignment of their primary and secondary sites;
    ii. communicate with physicians about the implications of having primary and secondary sites;
    iii. communicate with physicians any changes regarding their primary and secondary sites on a regular basis as part of their regular review with the local and regional department heads; and
    iv. take steps to ensure that call at the primary site should be equitable and not altered unless there is mutual agreement in writing between the physician and their primary site and/or unless there are extraordinary circumstances that would not permit such an equitable arrangement. (collectively termed hereafter "Policy")

[1] As set out in Rule 12(4) of the HAB's Rules of Practice and Procedure, the usual practice of the HAB is for the Respondent to present its case first.

[34] At the end of closing submissions and without prior notice to the Respondent, the Appellant made a claim to be added to the current MOCAP for RCH. The Respondent objected to the inclusion of this additional claim for relief but the Panel ruled that there was no need to hear from the Respondent for the reasons set out below.

[35] As discussed further below, following the close of the hearing the Appellant again sought to vary the remedy sought to include two on-call shifts, the position adopted at the opening of the hearing.

[36] The varied and contradictory positions taken by the Appellant are addressed below.

ISSUES

[37] In determining this appeal, the Panel has considered the following issues:

1. **Whether the HAB has jurisdiction to hear the appeal.**

2. **If so, whether the appeal is moot.**

3. **If the HAB does have jurisdiction and the appeal is not moot, whether the Appellant should be granted the Declaration, Policy and addition to MOCAP.**

4. **The merits of the decision under appeal refusing the Appellant on-call privileges and/or morning pediatric coverage at RCH.**

5. **Whether the appeal should be reopened to hear additional evidence and allow an amendment of the remedy sought by the Appellant.**

[38] Each of these issues will be considered below.

DISCUSSION AND ANALYSIS

1. Whether the HAB has jurisdiction to hear the appeal.

[39] The question to be determined in considering the jurisdictional issue is whether the Appellant continued to have on-call privileges at RCH after he transferred to the SMH Neonatologist department in February 2010, and if so, were they modified, revoked or constructively revoked by the FHA Board of Directors' decision of May 9, 2014, not to grant the Appellant full or partial on-call privileges at RCH;

a) if no, the HAB has no authority and the appeal must be dismissed;

b) if yes, the appeal will be considered on the merits, subject to mootness.

Primary site

[40] The Respondent says physicians have only one primary site and it is at this primary site where they are obliged to provide on-call services and consequently it is at only one site where physicians are granted on-call shifts. If this is correct, and the Appellant's primary site is SMH, then the Respondent submits the Appellant has neither on-call privileges nor any on-call obligations at RCH. Without such privileges, the Respondent says the appeal must fail as the Board of Directors' decision to uphold the RCH decision to withdraw on-call shifts from the Appellant would not be a change in his privileges.

[41] The HAB as a statutory tribunal has only those powers granted by its enabling legislation and is therefore limited in its authority. The *Hospital Act* provides:

> **Hospital Appeal Board**
>
> **46** (1) The Hospital Appeal Board, consisting of the members appointed under subsection (4), is continued for the purpose of providing practitioners appeals from
>
> (a) a decision of a board of management that modifies, refuses, suspends, revokes or fails to renew a practitioner's permit to practise in a hospital, or
>
> (b) the failure or refusal of a board of management to consider and decide on an application for a permit.
>
> (2) The Hospital Appeal Board may affirm, reverse or substitute its own decision for that of a board of management on the terms and conditions it considers appropriate.

[42] If a decision of the board of management (in this case the Board of Directors of FHA) does not "modify, refuse" etc. a practitioner's permit to practise then there is no authority for the HAB to hear the appeal.

[43] In this appeal, the Respondent raised a preliminary objection to the HAB's jurisdiction to consider the appeal. It submitted that because the Appellant has changed his primary site to SMH and that on-call privileges were only available at a primary site, the Appellant had no on-call privileges at RCH despite the fact that he may have been on the roster to fill occasional vacancies. The obligation and entitlement for on-call solely at the primary site does not prevent a physician from also seeking non-obligatory extra shifts at a secondary site on an as needed basis. However, the Respondent submits that the decision of the RCH department to remove the Appellant from the on-call rota (a non-obligatory assignment) at a secondary site was therefore not a modification of privileges but an operational decision immune from appeal.

[44] The parties disagreed as to whether this jurisdictional challenge should be determined by the HAB as a preliminary matter or as part of a hearing on the merits.

[45] The HAB held in a preliminary decision in this case (Decision No. 2014-HA-002(a)) that it was not clear on a review of the January 2, 2013 Medical Staff Bylaws that a practitioner could not have on-call privileges at more than one site. The Appellant was and remains a member of the active staff at SMH, RCH and

Eagle Ridge Hospital. Bylaw 6.3.6 requires active staff to participate in on-call responsibilities. The Appellant submitted that as there was no definition of "primary site" it could not be determined simply on a review of the Bylaws that on-call privileges were restricted to one site. The HAB agreed and determined that a full hearing would be required to determine the content of active staff privileges at multiple sites, with leave to the Respondent to raise its objection regarding the authority of the HAB to hear the appeal at the hearing.

[46] At the hearing, the Respondent renewed its objection to the HAB's authority to hear the appeal.

[47] Some history is required to understand the evolution of the concept of primary sites. Before the creation of regional health authorities, privileges were granted at individual hospitals and the issue of multiple sites was not a concern of the bylaws.

[48] When the FHA was created, it adopted Medical Staff Bylaws and Rules that governed the whole authority.

[49] There are references to "primary site" in the Rules but, as noted above, no definition. For example, in the October 13, 2010 Rules, Rule 2.18.4 provides that local heads of departments must have been appointed to that facility as the Member's "primary site". Applicants for membership as medical staff are appointed to a primary regional department and "primary site" (Rule 3.6.4).

[50] Dr. M, the Vice President Medicine for FHA, testified the FHA pediatric department changed from a site-based to a regional department in 2009. Many members of the regional department had active staff privileges at multiple sites but he testified it was well understood that members only had on-call responsibilities and accordingly only had on-call privileges at their primary site.

[51] Dr. M testified that no member in the FHA has on-call privileges or obligations at more than one site. He said it would be a scheduling "nightmare" to manage on-call at multiple sites. Further, it would be a breach of contract by the FHA to compel members to provide on-call at more than one site.

[52] Five neonatologists testified at the appeal. Dr. C and Dr. K from RCH confirmed that although they had active staff privileges at more than one location this was purely for administrative convenience. It allowed staff on rare occasions to provide back-up to other sites where there were staff issues. This was confirmed by Dr. S, the FHA regional department head for pediatrics and Dr. V, the local department head at SMH who testified for the Appellant.

[53] The Appellant himself provided no evidence that he was required to provide on-call services at more than one site. He also did not contradict the evidence of any of the other witnesses who testified that there was no requirement to provide on-call services at multiple sites. In argument, he simply points to Bylaw 6.3.6 which states:

> Unless specifically exempted by the Health Authority, members of the active staff are required to participate in fulfilling the organization and service responsibilities, including on-call responsibilities, of the Regional Department to which the member is assigned, as

> determined by the Health Authority and described in Medical Staff Rules.

[54] The Panel heard evidence that there were proposals to develop a "one department, two sites" model for RCH and SMH. This would have meant that all neonatologists would be members of a single regional department and could be required to provide services at multiple locations. However, this proposal was never implemented and the two sites continued to operate as separate local departments.

[55] The Appellant was unable to provide us with evidence that he had on-call privileges at multiple sites. The sequence of events set out below in discussing whether the Appellant did change primary sites in early 2010 confirms that the RCH department made it abundantly clear to the Appellant that if he transferred to SMH he would no longer be a member of the RCH department with on-call privileges. The fact that the Appellant was offered two on-call shifts for three years after his transfer was not a confirmation of his on-call privileges. Rather, it was an operational decision made by the RCH as they required assistance during the confusing period when FHA could not come to a final decision about the model of care it would provide in the regional pediatric department and could thus, not come to a final decision on the type of physician it needed to hire to fulfill staffing needs.

[56] The Appellant testified that it was his understanding that he would be able to work at more than one site indefinitely. Although he did have additional on-call shifts at RCH for some time after his move to SMH, his "understanding" that RCH shifts continued to form part of his privileges was not supported by the evidence at the hearing.

[57] The FHA has proposed amendments to the Bylaws and Rules as of June 2016 to make it clear that active members have only one site with on-call privileges. If a member has privileges at secondary site or sites, this is only for administrative convenience – back up as needed.

[58] The Appellant argued that these amendments were in effect a concession that "primary site" was a new concept with the implication that prior to the introduction of these amendments members had on-call privileges at any site where they were an active staff member.

[59] The timing of the proposed amendments suggests otherwise. The HAB issued its decision on the Respondent's preliminary objection to the appeal in June 2015. The proposed amendments were drafted in July 2015. It is much more probable that the amendments were proposed to support future preliminary objections by making it clear to any subsequent panel that on-call privileges are restricted to the primary site. The proposed amendments that were drafted in apparent response to the HAB's preliminary decision on its authority are therefore not confirmation that the nature of privileges has changed but merely clarifying the long-standing tacit understanding of the players in the hospital system that on-call privileges only exist at the member's primary site.

[60] The Panel finds that the invariable practice was for active staff to have primary site on-call privileges, and appointments to secondary sites were only for operational convenience allowing for back-up on an as-needed basis.

[61] The Appellant himself provided a good example of why this is so. He was asked in cross-examination why he didn't seek additional on-call shifts at other sites besides RCH if he needed more experience or income. He replied that he needed to be within fifteen minutes travel time to a site. So for example, if he wanted to provide on-call services at a remote hospital he would have to rent a motel room nearby. If any physician, for instance, could be a member of the active staff at multiple sites, then that physician would also be obliged to provide on-call at each of the multiple sites. This would result in major administrative difficulties – balancing the schedules of multiple locations and many physicians, considering distance to the facility and would create an impossible situation.

[62] The Appellant had applied for active staff membership at SMH in 2009 This was finally confirmed by Dr. W, then Vice President Medicine FHA, in a letter to the Appellant dated December 4, 2012, that confirmed SMH as his primary site and Eagle Ridge Hospital and RCH as secondary sites.

[63] We note in passing that had this appointment been confirmed in writing in a timelier manner it may have obviated this appeal. Similarly, we note that had the letter more clearly spelled out the meaning of primary sites and their requirements and obligations, as well an explanation of the cessation of the RCH as a primary site, this appeal may not have been pursued.

Did the Appellant switch primary sites to SMH?

[64] We have found that an active member only has on-call privileges at a primary site. The Appellant goes on to argue that, even if he is restricted to on-call privileges at a primary site, in fact he never resigned from the RCH department and therefore the reduction of his on-call shifts from six per month to two per month in February 2010 was a modification of his privileges as was the elimination of his on-call shifts at RCH altogether in December 2012.

[65] Analysis of the evidence at the hearing strongly supports a conclusion that in fact the Appellant did transfer his primary site to SMH in late 2009 or early 2010.

[66] The FHA confirmed in an April 9, 2009 "update" that the transfer of all Level 3 beds to SMH would occur on February 1, 2010. The Appellant was clear throughout to his peers at RCH, the transition team from FHA and the neonatology department at SMH that he intended to pursue his career as a neonatologist at whatever facility offered him access to tertiary care.

[67] As noted above, the RCH department had resolved May 7, 2009, that its members had to determine where their full-time practice would be located.

[68] In the December 3, 2009 minutes of the RCH department meeting, it was noted "Dr. Sorokan also said after the meeting that after the move he will be working three-quarter time in Surrey Memorial and one-quarter in RCH".

[69] In his testimony, the Appellant was visibly annoyed by what he viewed as errors in these minutes and made several contradictory statements about them. He claimed in direct examination that he never made the statement during the meeting which was minuted as occurring after the meeting and the Appellant took issue with Dr. K making a minute of something allegedly said after the close of business in the meeting. In cross-examination he said he didn't recall making that statement or that Dr. K had misunderstood. He conceded in cross that he had an opportunity to correct the minutes at the January 2010 meeting but did not do so.

[70] In response to questions from the Panel, the Appellant said that he had decided to transfer the bulk of his practice to SMH in late 2009.

[71] We find that the entry in the minutes of the Appellant's decision to switch sites was entirely plausible. Although the Respondent did not make this argument, the minutes are clearly business records that were made contemporaneously by a party (the chairperson) who had a duty to record them and as such presumptively admissible to confirm the statement was made by the Appellant. Although the Appellant believes otherwise, it is not surprising that the chairperson (Dr. K) would make a note, whether during the official meeting or afterwards, when one fifth of their department announced, after a year of highly contentious dealings with the FHA about the proposed transfer, that he was shifting the bulk of his practice elsewhere. Also, the minutes clearly showed that the note of the conversation did occur after the meeting.

[72] Much later, the Appellant tried to enlist the support of Dr. VA in his quest to be reinstated at RCH. Dr. VA was a consultant retained by FHA to facilitate the creation of a true regional pediatric department along the lines of the "one department two sites" model discussed above. Dr. VA's goal was eventually thwarted by the lack of cooperation, especially from RCH, and he eventually left the FHA.

[73] Dr. VA in a December 15, 2011 email to the Appellant said "When you 'moved' from RCH to SMH, could that have been perceived by others as you leaving RCH? I understand where you are coming from and may see it as 'a slap in the face', but what matters is the perception by OTHERS." (emphasis in original).

[74] We find Dr. VA to be correct. In our view, the RCH department had resolved by May 2009 that members needed to 'choose which side they're on', while making it clear most physicians were unalterably opposed to the proposed transfer, going so far as to say they would fundamentally alter their neonatology practice and lose access to tertiary care rather than transfer to SMH. In contrast, the Appellant, intent on preserving his tertiary care practice, made a decision in late 2009 to transfer his practice to SMH to coincide with the February 1, 2010 date that had been previously announced by FHA.

[75] After receiving this information and believing that the Appellant had moved his primary site to SMH, Dr. C amended the February 2010 on-call rota to remove the Appellant from any obligation to perform on-call services. However, as the department was short staffed and the Appellant was both interested in working at

RCH and was knowledgeable on RCH department matters, Dr. C continued to assign 2 shifts per month to the Appellant as needed.

[76] As required by his employer, the Appellant signed a memorandum of understanding ("MOU") along with the other four members of the SMH neonatology department and the FHA to provide 24 hour/7 days a week/ 52 weeks a year on-call coverage.

[77] The Appellant argued that he was in effect forced to sign this agreement, firstly because he had to follow tertiary care to protect his career and secondly because his shifts had been reduced at RCH. We reject that proposition.

[78] We acknowledge that the choice of a primary site in these circumstances was a difficult decision for the Appellant and the other physicians and not without some element of risk. However it was a choice that each of the physicians were required to, and did make. The fact that the Appellant chose SMH because tertiary care was being transferred goes to his motive, not his intent. As we will see below, the transfer did not proceed on February 1, 2010, and in fact there was no substantial tertiary care at SMH until 2013. We note that in the RCH memos on the progress of the transfer, the FHA acknowledged that there was confusion for all members of the team. Nonetheless, the Appellant clearly made a decision to transfer his practice, albeit based on, as it turned out, incorrect information received from the Health Authority.

[79] The contention that he moved his primary site to SMH because his hours were reduced at RCH is not credible. The Appellant had been an active, arguably key, member of the transition team for a year. At every department meeting it was made clear that the remaining members of RCH opposed the transfer while the Appellant supported, or at a minimum condoned it. As indicated earlier in this decision, the Appellant takes issue with the clear December 2009 minutes that show his stated intention to move but did not contest them when he had an opportunity to do so in January 2010.

[80] We find that it is entirely reasonable that the RCH department concluded in December 2009 that the Appellant had opted to leave RCH and join SMH. Given their previous clear resolution and the explicit intention of FHA that members needed to choose a primary location, the Appellant had chosen SMH. The elimination from the obligation to provide on-call services combined with the reduction in his on-call shifts in February 2010 due to operational constraints was therefore an effect of his transfer, not a cause.

[81] Dr. V testified that the Appellant assisted in calculating the fees paid under the MOU. The Appellant also assisted in calculating the fees in the Alternative Payment Plan ("APP") for SMH that was effective November 1, 2010. Both the MOU and the APP require full-time equivalent commitment to SMH by all signatories, including the Appellant. The APP required each neonatologist to provide between 1680 and 1950 hours per year. The Appellant testified his on-call commitment to RCH had previously been 1800 hours per year. The obvious conclusion is that he shifted from a full-time position at RCH to a full-time position at SMH.

[82] After the Appellant had transferred to SMH, FHA changed its mind about the transfer of Level 3 beds. On April 23, 2010, the decision was made by FHA due to lack of obstetric and anesthetist support at SMH that the Level 3 beds would stay at RCH. The Appellant immediately attempted to re-gain primary site privileges and on-call obligations back at RCH. Given his motivation to follow the Level 3 beds, the Appellant realized that with FHA's change of direction, his choice had now become the wrong choice.

[83] The Appellant consistently and continually asked to be returned to RCH, initially with additional shifts to his existing two on-call shifts per month and then to requesting full-time transfer back from SMH to RCH. His efforts commenced around March 2010 and have continued unabated until this hearing, with only some changes to the number of shifts requested.

[84] The RCH department continued to provide two on-call shifts from February 2010 until December 2012. Their view was that there was no need to have additional shifts from the Appellant and they resented what they perceived as the Appellant's cherry-picking on-call work (as noted above the main source of income for the department) while not contributing to the unpaid work of administration, teaching and pediatric rounds.

[85] When the Appellant transferred to SMH, regardless of his reasons and the effect, it meant that he ceased to be a member of RCH. RCH's unique model meant sharing fees, unpaid duties and on-call. There was no opportunity to introduce a part-time position and the current funding model would not be able to support a part-time neonatologist position.

[86] Although the Appellant remained on the on-call roster at RCH, we find that he had neither a temporary nor permanent part-time position at RCH. We also find that FHA made no representation to the Appellant that he could maintain a full-time position at both sites, or a part-time position in the RCH group.

[87] During the several years after the April 2010 decision by FHA to delay the Level 3 transfer, RCH continued to suffer uncertainty with loss of nursing staff and referrals. Many patients were referred outside of the FHA altogether.

[88] The Appellant seemed to believe and continue to believe that his privileges allowed him to participate in on-call to whatever level suited him at whatever facility he chose. We find this is not the nature of his or any physician's privileges. By opting for SMH as his primary site in order to follow the Level 3 work he believed was being transferred, he simultaneously abandoned RCH as a primary site, whether or not he intended this to happen. Even though he continued to have on-call shifts at RCH, those shifts were not obligatory and were the same type of voluntary shift any other back-up physician, such as Drs. C, K, S and V would have had at multiple secondary site hospitals. As of February 2010, we find that the Appellant had voluntarily changed his primary site to SMH.

[89] The Appellant claimed at the hearing that he did not understand the difference between primary and secondary sites. However, under cross-examination he acknowledged sending an email to Dr. W on June 6, 2010, where he said that he needed to pick a primary site, using that specific term.

[90] The Appellant argues it is incorrect to view the transfer of primary sites as "voluntary". This is because as a skilled neonatologist he needed access to Level 3 facilities. However, this only explains his motive for transferring. He transferred under the honest but mistaken belief that FHA would implement the transfer of Level 3 beds as it had announced, albeit that announcement was premature and under a cloak of confusion. Because the Appellant chose to transfer his primary site to SMH, and with it his on-call obligations, there was no "modification etc." as per section 46 of the *Hospital Act* to his Active Staff privileges when his on-call shifts at RCH, his secondary site, were reduced in February 2010 and eliminated in December 2012.

[91] As the Appellant gave up his on-call privileges at RCH in February 2010, the RCH decision to grant part-time on-call until they no longer required his services was for the administrative or operational convenience of RCH. The continued grant of part-time on-call did not create or confirm that the Appellant had on-call privileges. Thus the decision by the RCH to no longer grant the Appellant two on-call shifts per month effective December 2012 did not "modify etc." his privileges as envisioned by section 46 of the *Hospital Act*. The Board of Directors' decision to not reverse the RCH decision is therefore not appealable to the HAB.

[92] As the Panel has determined that the HAB has no authority to hear the appeal, it is dismissed.

[93] However, should we be incorrect in our finding that we have no jurisdiction in this matter, and since the Appellant maintains he was treated unfairly and has sought an alternative remedy, namely a Declaration and Policy recommendation, which the Respondent has opposed on the grounds of mootness, and given there was extensive argument on these points, the Panel will nevertheless consider this issue.

2. Whether the appeal is moot.

[94] During the hearing and after consultation with his counsel, the Appellant abandoned his original remedy which sought reinstatement of two on-call shifts a month at RCH plus morning coverage of the pediatric ward. The Appellant now seeks a Declaration by the Panel that his privileges were wrongly taken from him, and as a remedy, says the Panel should recommend the Policy changes to the FHA. As noted above the Appellant, late in the appeal, in fact during final submissions, also sought to be added to the RCH MOCAP. As the Appellant has abandoned his initial remedy and only seeks a Declaration and Policy, the Panel must consider whether the appeal is moot, and if not, whether the HAB has authority to make the Declaration or recommend the Policy.

[95] The remedy sought by the Appellant has changed significantly in the course of the appeal.

[96] In his January 24, 2014 presentation before the Board of Directors, the Appellant sought reinstatement of full-time participation on the on-call rota schedule at RCH or in the alternative three on-call shifts per month.

[97] In his August 18, 2014 Notice of Appeal the Appellant sought reinstatement of full on-call privileges and financial compensation for reduction of on-call to two per month then reduction to no calls.

[98] At the opening of the appeal he sought two on-call shifts plus morning coverage of the pediatric ward.

[99] In the course of cross-examination he abandoned that claim and in closing, sought the Declaration and Policy relief outlined above.

[100] Finally, at the end of oral closing argument he sought to be added to the MOCAP for RCH.

[101] The HAB is a statutory tribunal. It does not have inherent jurisdiction. Nowhere in the *Hospital Act* is it set out that the HAB has declaratory power.

[102] We have found that the Appellant no longer had on-call privileges at RCH effective February 2010. Accordingly, we have found that the decision of the Board of Directors to not grant further on-call shifts was not a modification etc. of the Appellant's privileges.

[103] Even if the HAB has authority to declare that the Appellant's privileges were modified without also overturning the decision of the Board of Directors, we would not do so in this case as the Board of Directors correctly determined that the Appellant ought not to be granted further on-call shifts except at the discretion of the RCH department. The Appellant had no "right" to on-call privileges at RCH once he transferred his hospital practice to SMH as his primary site, which this Panel has found he did.

[104] If, however, we are incorrect with respect to finding the Appellant had no on-call privileges at RCH at the relevant times, should we declare that the Board of Directors has modified the Appellant's privileges if no remedy is sought to overturn that decision?

[105] The Respondent says no. The Respondent submits that any finding of the Panel of either a declaration or policy would be moot as the original appeal with respect to "modification etc." of the Appellant's privileges is moot. We agree.

[106] *Borowski v. Canada (Attorney General)*, [1989] 1 SCR 342 sets out the definitive test for mootness at p. 353:

> "Mootness
>
> The doctrine of mootness is an aspect of a general policy or practice that a court may decline to decide a case which raises merely a hypothetical or abstract question. The general principle applies when the decision of the court will not have the effect of resolving some controversy which affects or may affect the rights of the parties. If the decision of the court will have no practical effect on such rights, the court will decline to decide the case. This essential ingredient must be present not only when the action or proceeding is commenced but at the time when the court is called upon to reach a decision. Accordingly if, subsequent to the initiation of the action or proceeding, events occur which affect the relationship of the parties so that no present live controversy exists which affects the rights of the parties,

> the case is said to be moot. The general policy or practice is enforced in moot cases unless the court exercises its discretion to depart from its policy or practice. The relevant factors relating to the exercise of the court's discretion are discussed hereinafter.
>
> The approach in recent cases involves a two-step analysis. First it is necessary to determine whether the required tangible and concrete dispute has disappeared and the issues have become academic. Second, if the response to the first question is affirmative, it is necessary to decide if the court should exercise its discretion to hear the case. The cases do not always make it clear whether the term "moot" applies to cases that do not present a concrete controversy or whether the term applies only to such of those cases as the court declines to hear. In the interest of clarity, I consider that a case is moot if it fails to meet the "live controversy" test. A court may nonetheless elect to address a moot issue if the circumstances warrant."

[107] In this appeal the Appellant no longer seeks to overturn the Board of Directors' decision. Accordingly, there is no "live controversy" between the parties and the appeal is moot. Further, we are not persuaded that this is an appropriate case to exercise our discretion to nevertheless uphold the appeal when the Appellant has abandoned his original claim, for the reasons set out above.

3. Whether the Appellant should be granted the Declaration, Policy and addition to MOCAP.

Declaration

[108] The Appellant cites *Fung v. South Fraser Health Region* February 27, 2001, Hospital Appeal Board, ("*Fung")* as authority for the HAB to make comments on the conduct of the respondent even if no remedy is sought.

[109] In *Fung* the appellant had been placed on probation based on allegations of failing to carry out his responsibilities. Dr. Fung had full privileges as of the date of the hearing and the panel raised the issue of mootness. Dr. Fung submitted that having been placed on probation was part of his "record" and could have a negative impact on future applications for privileges. The respondent did not challenge the authority of the HAB to hear the appeal although the original remedy sought (reinstatement of privileges) had become moot.

[110] There was no evidence before this Panel that the Appellant will face future negative consequences because he has not continued to have two on-call shifts per month at RCH. That is sufficient to distinguish *Fung*. This Panel in addition has doubts as to the correctness of the *Fung* decision and notes that the panel in that case does not seem to have had the benefit of full submissions on the question of mootness. In fact, in *Fung* there was evidence that the appellant, having been granted privileges, no longer needed a remedy from the HAB.

[111] We note that *Fung* dealt with a service record and arguably was not moot. We also doubt the correctness of *Fung* in any event given the HAB's limited

statutory authority and the absence of a live dispute between the parties in that case. In any event, it is well understood in administrative law that the doctrine of precedent that binds courts (known as "*stare decicis*") does not apply to administrative tribunals such as the HAB which are not bound by previous decisions of a panel of the tribunal.

[112] The Appellant candidly admitted that granting the Declaration sought could give rise to further appeals as it would be confirmation that the Appellant does indeed have on-call privileges at RCH. The Panel cannot countenance split or duplicative proceedings.

Policy

[113] Even if the appeal were not moot, we would decline to make the Policy recommendations sought. The Policy relief sought is not appropriate. The recommendations sought have potentially far-reaching consequences to the operations of the FHA. There was no evidence lead on the implications for management or budgets of FHA if the Policy was implemented. Some of the changes sought are to Medical Staff Bylaws and Rules which are a potential infringement on provincial authority. Most importantly, none of the Policy recommendations were put to the Respondent's witnesses nor was the Respondent put on notice prior to the hearing. The Respondent may have opted to call evidence on the Policy recommendations and cross examine the Appellant. It lost that opportunity because of the late notice which this Panel finds would cause the Respondent significant prejudice.

MOCAP

[114] This last point also disposes of the very late additional remedy requested by the Appellant of seeking his addition to MOCAP contracts. The latest MOCAP has eight physician signatories together with FHA. We have no jurisdiction to amend or repeal a contract between private parties, particularly when they were not parties to this appeal. There was no evidence lead of the effect of adding the Appellant to the RCH MOCAP on operations or on the privileges of neonatologists. There was a complete lack of evidentiary or legal basis put forward for this claim and given the very late introduction of this remedy (at the close of Appellant's oral closing and without prior notice to the Respondent) accepting this remedy so late in the proceedings would cause grave prejudice to the Respondent. This remedy is denied.

[115] In summary then, for the reasons outlined above, the Panel has concluded that the decision appealed from does not fall within the purview of section 46(1)(a) of the *Hospital Act*, and the appeal is therefore dismissed. Further, we have found that even if it did, the appeal would be dismissed as being moot as to the relief the Panel could lawfully order under section 46(2). Further, the Declaration and Policy relief requested by the Appellant has been denied as being inappropriate and outside the jurisdiction of the HAB.

[116] However, since this appeal was fully presented and argued on the merits of the Board of Directors' decision, over the course of five oral hearing days, we have nevertheless considered whether we ought to address the merits in the alternative should we be found at some future date to have committed a

reviewable error on the preliminary issues above. In our view, it is just and appropriate to do so and we consider it advisable in order to ensure that the parties and any reviewing Court have the benefit of the totality of our reasons on all of the issues that arose in the course of this appeal.

4. The merits of the decision refusing the Appellant on-call privileges and/or morning pediatric coverage at RCH.

[117] In our view, the relationship between the Appellant and the RCH department was damaged once he elected to transfer to SMH. Even though FHA delayed and finally reversed its decision to move the Level 3 beds to SMH, and notwithstanding the confusion FHA caused for staff throughout the period of uncertainty, the Appellant had already signaled his intention to follow the Level 3 work rather than be a committed full-time member of the RCH department with its unique model of care and compensation.

[118] The Appellant was signatory to several agreements with FHA committing to full-time services at SMH. His repeated requests to be granted additional on-call shifts at RCH was perceived by the RCH department members as an attempt to "skim the cream" i.e. share in the MSP payments for on-call work without contributing to the unpaid teaching and administrative work of the department.

[119] Although the Appellant lobbied for additional work at RCH, he never confirmed, even to the date of this hearing, that he would give up full-time on-call privileges at SMH.

[120] The staffing needs at RCH were in flux because of the abortive transfer. There was significant upheaval for neonatologists, pediatricians and nursing staff at both facilities. RCH's future as a tertiary centre remained in continued doubt. The loss of referrals and nursing staff meant lower case-loads and subsequently lower income for the RCH members who stayed. For sound operational reasons, RCH was unable to provide more than two on-call shifts per month to the Appellant.

[121] The Appellant also implied that he was dealt with unfairly. He argues that he was following the Level 3 work and when it stayed at RCH he should have been able to elect to stay at RCH with the Level 3 work.

[122] There are two aspects to what the Appellant argues is an injustice. He claims to have been hurt financially and also that his practice has suffered because he wanted to focus on tertiary work.

[123] The financial argument is unpersuasive. The Appellant testified that a typical on-call shift at RCH earned $7000 in fees. He was given 2 shifts per month which is $168,000 per year. His APP at SMH paid $330,000 per year, for a combined total of $508,000 per year. Had he continued at RCH with 6 shifts per month he would have earned $504,000 per year. In other words, from the period of February 2010 when the Appellant left RCH until December 2012 when his shifts were eliminated there was no demonstrable financial loss.

[124] With respect to quality of practice, Dr. V testified that the neonatologists he had recruited all had concerns that they had been hired for Level 3 work and had none at SMH during that time due to FHA's indecision at transferring the Level 3 beds. Some of those neonatologists considered working out of the country. Only the Appellant continued to have access to Level 3 work for three years after his transfer to SMH by accessing available shifts at RCH.

[125] The Appellant's shifts at RCH ended December 2012. Dr. V and the Appellant testified that SMH finally had their Level 3 beds granted by FHA in 2013. In other words, the "loss" the Appellant suffered in terms of income and quality of practice was at most a few months in 2013.

[126] Dr. V testified that the MOU and APP were calculated (with assistance from the Appellant, due to his knowledge of and familiarity with funding formulas) to replace the expected fee for service for full time members of the SMH neonatology department. In other words, the Appellant was paid the same as if the Level 3 beds had been transferred as forecast. In fact, for 3 years the Appellant had the equivalent of full time pay from SMH plus 2/6 shifts at RCH, i.e. a 1.3 pay structure.

[127] Many physicians and nurses faced similar upheaval. The Appellant however received beneficial treatment in the form of continued access to Level 3 beds at both RCH and SMH plus potentially better compensation. The neonatologists who had been recruited to SMH in expectation of receiving all of the Level 3 beds from RCH had to deal with the fact that it did not play out as they had expected.

[128] The Appellant also says there has been an impact on his private practice in New Westminster. This is not a relevant factor. The HAB authority is restricted to consideration of changes to hospital privileges and private practice is of no concern to the FHA or to this Panel.

[129] The RCH department eventually decided to seek a full time neonatologist. An open competition was held and Dr. M was appointed in October 2012. The Appellant was an unsuccessful candidate for that position.

[130] This raises the question whether there is a need for further on-call shifts from Appellant as of the date of the hearing? The Panel finds there is not. This is effectively conceded by the Appellant by his abandoning that remedy. Since the Board of Directors' decision was made, the RCH department has hired Dr. D, a pediatrician specializing in eating disorders, Dr. M as noted, and Dr. H, a neonatologist/cardiac specialist. Accordingly, there is no need for additional on-call shifts or pediatric morning call from the Appellant.

[131] Further, we note that the NICU department at RCH is very small and given their structure highly dependent on mutual trust. The Appellant has instituted civil proceedings against his colleagues, or some of them, in the BC Supreme Court seeking remedies arising from civil conspiracy and malice. Given these allegations, it would be highly detrimental to the operations of the RCH department to force admission of the Appellant to the on-call list.

[132] The Appellant argues, citing *Prairie North Regional Health Centre v. Kutzner* 2010 SKCA 132, that complete removal of his on-call privileges from RCH means

he has been "constructively dismissed". In *Prairie North* the appellant lost all opportunity to practice in a hospital. In the case under appeal the Appellant continues to have full-time privileges at SMH. He has not been constructively dismissed. He has transferred his practice from one site to another. Having done so he no longer can claim on-call privileges at his former site. The Appellant had the benefit of a 1.33 equivalent practice for 3 years after he transferred (full time SMH; 2/6 shifts at RCH). This was not available to any other neonatologist at either RCH or SMH. In spite of this unique opportunity, both financially and in quality of practice, he avers that he has been dealt with unfairly. The Panel does not agree.

[133] In conclusion, even in the event that the HAB has jurisdiction to determine the appeal, and even if the appeal was not moot, we nevertheless would not allow the appeal on the merits as we have determined that the Appellant was not treated unfairly and there is no need for further on-call shifts from the Appellant.

5. Should the Appellant be granted leave to reopen the hearing to introduce new evidence and amend the remedy sought?

[134] In his application to reopen the hearing submitted March 30, 2017 the Appellant again varied the remedy sought. His latest submission is that he should be granted two 24-hour on-call shifts per month at RCH. The stated justification for amending the remedy sought is that evidence was lead at the hearing that there had been several new hires in the RCH NICU, including a cardiac neonatologist Dr. H. In his application to reopen the Appellant provided evidence (not contradicted by the Respondent) that in fact the planned hire of Dr. H commencing January, 2017 did not occur. The Panel was not provided with any information as to why this change occurred. The Appellant avers that had he been aware during the hearing that Dr. H would not be employed by the RCH NICU he would have maintained his position that he should be granted on-call shifts. Therefore the hearing should be reopened to hear this evidence and allow an amendment in the remedy sought.

[135] The parties are agreed that the HAB has jurisdiction under common law to exercise its discretion to reopen a hearing where, as in the present circumstances, the hearing has been completed but reasons not yet issued.

[136] The discretion is not unfettered and is subject to a long-standing test, recently discussed in *Bronson v. Hewitt* 2010 BCSC 871, a case submitted by both parties:

[137] "From my review of the authorities I take the law to be that new evidence will only be admissible on a reconsideration application if it would likely change the result and, except in exceptional circumstances, the evidence could not have been obtained by reasonable diligence before the trial" (at para. 33) The parties agree that the "new evidence" of Dr. H not being employed by RCH could not have been presented at the trial as of course the non-event occurred six months following the close of the hearing.

[138] This leaves consideration of whether the evidence would "likely change the result". We conclude it would not.

[139] Addressing the issues identified above, would the fact that Dr. H is not employed affect the question of jurisdiction? The answer is clearly no. It is immaterial to the issue of what privileges Dr. Sorokan had or did not have at RCH.

[140] Could the new evidence affect the issue of mootness? Yes. If Dr. Sorokan is permitted to amend his remedy to include a demand for on-call shifts that would create a "live controversy" between the parties. We find that if this new evidence was admitted and the remedy amended as sought then the appeal would no longer be moot.

[141] Could the new evidence affect the issue of whether the Appellant should be granted the remedies sought in his final submissions at the hearing, namely the Declaration, Policy and MOCAP? Although it is not clear from the application to reopen whether the Appellant is still seeking any or all of these remedies, clearly the addition of a new remedy of on-call shifts would not affect whether or not is appropriate to grant these remedies as well.

[142] Finally, could the new evidence affect the merits of the FHA decision, namely is there a need for further on-call services at RCH?

[143] Superficially it is possible. However the uncontradicted evidence at the hearing was that even before the expected hire of Dr. H the existing members of the NICU had no need for additional staff. It should be noted that Dr. M had been hired in a competitive process as a full-time staff member after Dr. Sorokan transferred his practice. The case presented by the Appellant did not dispute that the NICU was fully staffed.

[144] Finally, even if there was demonstrated need, which we find is not the case, should the HAB appoint Dr. Sorokan rather than direct FHA to hold a recruitment process?

[145] The evidence of the poisonous relationship in the once tight-knit NICU is overwhelming. It would be highly disruptive to the department to force it to welcome back Dr. Sorokan.

[146] Dr. Sorokan argues that had he known Dr. H would not be hired he would not have amended his remedy. As the Respondent correctly points out in their submissions, Dr. Sorokan had ample opportunity to consider his position both before and during the hearing. As the Respondent argues:

> "The change in remedies was an informed strategic decision made by the Appellant with the assistance of counsel from which he should not be permitted to resile"

[147] The Respondent relies on *Risorto v. State Farm Mutual Automobile Insurance Co.* [2009] O.J. No. 820 which held:

[148] "The policy reasons for the adoption of the two-pronged test are well-known, and have been discussed in a number of the cases to which I have referred. An orderly system of litigation requires that each party put his or her best foot forward. It contemplates that judgment will be rendered after each party has done so. Litigation by instalments is not to be encouraged. There is a strong interest in finality, which should only be departed from in exception

circumstances. Parties make strategic decisions in the course of litigation, and except in narrow circumstances they must be held to those decisions."

[149] We adopt that statement as correct and find there are no exceptional circumstances in this appeal to justify the introduction of new evidence nor allow an amendment of the remedy sought.

Bad Faith Allegations

[150] At the close of oral argument, the Appellant for the first time raised *mala fides* or malice against the RCH department. This was not raised in the Notice of Appeal, not raised in opening argument, and not put to any witnesses. There was no evidence lead by the Appellant that decisions were made in bad faith. The Appellant's argument was that the RCH department reasons given for not extending part-time on-call to the Appellant nor to reinstate full time call after FHA reversed their decision to transfer Level 3 to SMH were not plausible so the Panel should conclude that the reasons given were a charade. The Appellant submits that the RCH department members must have been motivated by malice towards him.

[151] This is a wholly baseless accusation. The Appellant is so certain of his own position it appears he believes that any disagreement cannot be reasonable and can only be explained by bad faith. This is confirmed by the evidence that the Appellant has commenced civil proceedings in the BC Supreme Court seeking punitive damages against his former colleagues at RCH for civil conspiracy.

[152] The Appellant sought costs in his Notice of Appeal but the Respondent did not seek costs. The HAB has authority to award costs as per section 47 of the *Administrative Tribunals Act*. That authority is discretionary and has never been exercised by the HAB. In *Behn v. Vancouver Island Health Authority*, December 31, 2010, the HAB discussed the appropriate approach to take in appeals under the *Hospital Act* and determined that costs will not generally follow the event unless there are special circumstances which warrant costs being awarded.

[153] It is well settled law in the superior courts that a party who makes baseless accusations of malice is at risk of an increased costs or special costs award against them. As the matter was not raised at the hearing nor has the Respondent sought costs, the Panel makes no findings on the appropriateness of costs in this appeal. We do however, strongly caution parties against making such unfounded allegations at any stage in an appeal to the HAB.

[154] We did not find any evidence whatsoever that the character of the RCH department members or FHA administration has in any way been lacking. The oral testimony (including that of the Appellant and his witnesses) and the documentary record make it abundantly clear that there were principled and transparent reasons for not reinstating the Appellant. It is particularly reprehensible to spring this accusation for the first time at the very close of oral argument without giving the maligned individuals an opportunity to respond.

DECISION

[155] The Panel has taken into account all of the evidence and argument in this case, whether or not it has been expressly referenced in these reasons.

[156] The Panel finds that:

1. The Appellant transferred his primary site to SMH on or about February 2010 and as of that date he no longer had on-call privileges at RCH. The Board of Directors' decision to not grant on-call privileges at RCH was therefore not a "modification" of the Appellant's privileges and the HAB has no authority to hear the appeal.
2. In the alternative, the amended remedy sought by Appellant of a Declaration and Policy relief is moot or in the further alternative beyond the authority of the HAB.
3. We find that the Appellant was not treated unjustly and there is no current need for additional on-call shifts at RCH had the appeal proceeded on its merits.
4. There is no basis to reopen the hearing.

[157] For all these reasons, the appeal and application to reopen are dismissed.

"David G. Perry"

David G. Perry, Chair
Hospital Appeal Board

"Corey Van't Haaff"

Corey Van't Haaff, Member
Hospital Appeal Board

"Dr. Kevin Doyle"

Dr. Kevin Doyle, Member
Hospital Appeal Board

December 19, 2017

APPENDIX A

AGREED STATEMENT OF FACTS

Background

1. FHA is a regional health authority and corporation pursuant to the Health Authorities Act, RSBC 1996, c 180. FHA is responsible for regional service planning, operations, and the allocation and management of its fiscal, human and capital resources to meet the health service needs of the residents of the Fraser Health region, as described in Schedule B of the Regional Health Boards Regulation, BC. Reg 293/2001.

2. FHA owns and operates various hospitals, including Royal Columbian Hospital ("RCH"), Surrey Memorial Hospital ("SMH"), and other hospitals. The thirteen hospitals in the Fraser Health region serve a population of approximately 1.69 million people.

3. The hospitals and health authorities in British Columbia operate within a statutory framework set out in the Hospital Act, RSBC 1996, c. 2009, the Hospital Act Regulation, BC Reg 121/97, and the *Health Authorities Act*.

4. Pursuant to the authority and requirements of the *Hospital Act*, the Board of Directors of FHA (the "FHA Board") has established the FHA Medical Staff Bylaws and Medical Staff Rules. The Medical Staff Bylaws are also approved by the Minister of Health as necessary for the administration and management of the hospital's affairs and to ensure the provision of a high standard of care and treatment for patients. The Medical Staff Rules are enacted pursuant to the Medical Staff Bylaws and approved by the FHA Board.

5. The Medical Staff Bylaws and Medical Staff Rules define the relationship between the FHA Board, and the FHA Medical Staff organization, and set out the medical administration governance structure of the health authority.

6. Physicians wishing to practice in any facility in FHA may only do so if they are appointed to the Medical Staff and granted a "permit to practice" as set out in the Hospital Act (also known as "privileges"), by the FHA Board.

7. The *Hospital Act*, the Medical Staff Bylaws and Medical Staff Rules set out the process for the granting of privileges. The Medical Staff Bylaws and Medical Staff Rules set out the associated rights and obligations related to the various categories of privileges.

8. In cases where a practitioner is dissatisfied with the FHA Board's decision with respect to his or her privileges, that practitioner's recourse is to appeal to the FHA Board or to the Hospital Appeal Board or both as set out in s. 46 of the *Hospital Act*.

9. As a condition of appointment to the FHA Medical Staff, applicants must agree to be governed by the requirements set out in the Medical Staff Bylaws, Medical Staff Rules, FHA policies, and, where applicable, affiliation agreements (Article 3.2.3, Medical Staff Bylaws) and the Appellant, Dr. Stephen Todd Sorokan, did so agree.

Tertiary Neonatology Services

10. Tertiary care centres provide specialty services for the most acutely ill or high risk patients in the health region. Level 3 care in a Neonatal Intensive Care Unit ("NICU") is the highest level of care required by the most acutely ill newborns. In British Columbia, there are only four NICUs offering Level 3 care, two of which are located within the Fraser Health region at RCH and SMH. Both of these units also offer Level 2 care.

11. Neonatology is a Division of FHA's Regional Department of Pediatrics. All neonatal services, including the RCH and SMH NICUs, are managed by FHA. This includes allocating the number and acuity level of beds as well as all the staffing.

12. Dr. Sorokan is currently a member of the FHA Medical Staff. He holds active staff privileges at SMH, RCH, and Eagle Ridge Hospital. FHA has assigned Dr. Sorokan's primary site as SMH.

13. Dr. Sorokan provides professional services as a specialist physician to patients in hospital.

14. Dr. Sorokan's professional corporation, Dr. S. Todd Sorokan Professional Corporation ("Sorokan Corp."), is a party to an Alternative Payment Plan Clinical Services Contract between a group of physicians and physician corporations and FHA for the provision of physician services in the Neonatal Intensive Care Unit ('NICU") at SMH (the "NICU Contract"). Under the NICU Contract, Dr. Sorokan is expected to provide one full-time equivalent of physician services, including call, as defined in Appendix 1 of the NICU Contract.

15. The five neonatologists at RCH are compensated for direct patient care services on a fee- for-service basis by the Medical Services Plan of British Columbia.

16. On-call availability services at RCH is governed by the terms of two Medical On-Call Availability ("MOCAP") contracts.

Tertiary Neonatology Services at RCH between 2001 and 2010

17. In or around 2001, Dr. Sorokan was appointed by the FHA Board to the Medical Staff as a member of the Department of Pediatrics at RCH and was granted hospital privileges to practice pediatrics and neonatology at that site. Since Dr. Sorokan's appointment to the Active Medical Staff in 2001, the RCH NICU has had a combination of Level 2 and Level 3 beds.

18. As a condition of his appointment and ongoing membership of the FHA Medical Staff, Dr. Sorokan agreed to abide by the FHA Medical Staff Bylaws, Medical Staff Rules, policies, and, where applicable, affiliation agreements.

19. Between 2001 and 2010, Dr. Sorokan was a member of the Department of Pediatrics at RCH, along with Dr. C, Dr. O, Dr. K, and Dr. OT. Dr. A joined the RCH Department of Pediatrics in 2009 when Dr. OT retired from practice in the RCH NICU. However, Dr. OT continued to practice general pediatrics at RCH until February 28, 2015.

20. Between 2001 and 2010, the members of the Department of Pediatrics at RCH, including Dr. Sorokan, participated approximately equally in the on-call schedule.

21. Dr. Sorokan's community practice in New Westminster is a private office practice which is separate and distinct from FHA. FHA has no relationship with that practice.

FHA's Tertiary Perinatal Transition

22. In or around 2009, FHA announced its strategic operational plan to transition its tertiary perinatal program to SMH (the "Tertiary Perinatal Transition"). The term "perinatal" refers to antepartum, intrapartum and postpartum services provided to women and infants between 22 weeks gestation and seven days after birth.

23. FHA planned to transfer its high-risk obstetrical services and Level 3 NICU beds to SMH. RCH would continue to provide low-risk obstetrical services at RCH and the RCH NICU would continue as a Level 2 nursery.

24. The members of the Department of Pediatrics at RCH, including Dr. Sorokan, were asked to participate in the transition of all tertiary perinatal services, including neonatology, from RCH to SMH.

25. The transition of the Level 3 NICU beds to SMH was expected to begin on or around January 31, 2010. In February of 2010, four Level 3 NICU beds were transferred from RCH to SMH. However, the transition was subsequently delayed.

FHA's decision to maintain a Level 3 NICU at RCH

26. In early February of 2010, four Level 3 NICU beds were relocated from RCH to SMH. FHA planned to relocate the remaining beds by the end of March 2010. However, this did not occur.

27. In April of 2010, the Tertiary Perinatal Transition project was delayed for an indeterminate amount of time.

28. Since February of 2010, both RCH and SMH have provided Level 3 care to neonates in the FHA. Between these two hospitals there are currently a total of 52 NICU beds: 24 at RCH and 28 at SMH. Today there are twelve Level 3 beds in the RCH NICU and 8 Level 3 beds in the SMH NICU. FHA has plans to increase the number of beds in the SMH NICU.

The 2011 search and selection of a new neonatologist at RCH

29. In or around October of 2011 FHA declared and advertised for a full-time tertiary neonatologist and level 2 pediatrician to work in a 1 in 5 rotation with the other four members of the RCH Group (the "2011 Vacancy"). Dr. Sorokan was advised by Dr. VA that he could apply for this position.

30. Dr. Sorokan was interviewed by the Selection Committee, but he was not the successful candidate recommended to the FHA Board for appointment.